TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON ORTHOPEDIC SURGICAL HOSPITAL LLC

Respondent Name
ACCIDENT FUND INSURANCE CO OF AMERICA

MFDR Tracking Number
M4-15-4137-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
AUGUST 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are submitting this claim to you as an appeal. This claim was denied, EOB states authorization number missing, invalid, or does not apply. Please see the attached Coventry authorization dated 3/11/15. For dates of service 3/6/15-5/1/15. Service was provided within the dates that were authorized. Please reprocess this bill. Full payment is now past due."

Amount in Dispute: $85.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement was denied for the reasons outlined in the Carrier's explanation of benefits issued in response to each bill. Carrier stands by its reasons for denial as outlined in the EOBs. Provider has not established that it is entitled to reimbursement of $85.50."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2015	CPT Code 73510-RT-TC X-Ray Exam of Hip	$85.50	$40.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 293-This procedure requires prior authorization and none was identified.
   - 802-Charge for this procedure exceeds the OPPS schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Is the requestor entitled to reimbursement for right hip X-Ray performed on March 16, 2015?

Findings

1. The insurance carrier denied reimbursement for the disputed right hip X-Ray based upon reason codes "15" and "293".

   28 Texas Administrative Code §134.600(p)(8)(A) states, "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The requestor submitted a report dated March 11, 2015 from Coventry Workers' Comp Services that preauthorized a right hip x-ray, two (2) views, to be performed once (1) from March 6, 2015 through May 1, 2015. The requesting provider listed was Dr. Suzanne Manzi. A review of the report finds that the report does not specify where the x-ray was to be performed. Furthermore, the bill lists Dr. Manzi and the preauthorization reference number of 10951901; therefore, the Division finds that the respondent's denial based upon reason codes "15" and "293" are not supported.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   The 2015 DWC conversion factor for this service is 56.2.

   The Medicare Conversion Factor is 35.7547.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77401, which is located in Bellaire, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

   The Medicare Participating Amount for Technical component of code 73510 is $25.88.

   Using the above formula, the Division finds the MAR is $40.68.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $40.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $40.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		09/11/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.